TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

Stated Meeting, February 13, 1901.

The President, B. FARQUHAR CURTIS, M.D., in the Chair.

STRANGULATED HERNIA; OPERATION UNDER LOCAL ANÆSTHESIA.

DR. ARTHUR L. FISK presented a man, sixty-one years old, who entered hospital, with a double inguinal hernia, on November 19, 1900, complaining of considerable pain in the hernia on the right side. He was also suffering from a severe chronic bronchitis.

The case was regarded as one of incarcerated hernia, and the patient was kept under observation for twenty-four hours. He then had a severe attack of vomiting, the vomited material containing much fæcal matter. On account of the condition of the man's lungs, it was decided to operate at once under local anæsthesia. After the administration of a hypodermic of morphine (one-eighth of a grain), about four drachms of a 1 per cent. solution of cocaine were injected along the line of the proposed incision, and the right hernia was cut down upon. At the neck of the sac, a strangulated knuckle of intestine was found; as it was in good condition, it was released and returned to the abdominal cavity. The wound was then closed and the man made an uninterrupted recovery. He suffered little or no pain during the operation, and was so well pleased with the result that a month later he requested that his hernia on the opposite side be operated on. This was done on December 24th last, also under local anæsthesia. His recovery was uneventful.

INTUSSUSCEPTION.

DR. F. KAMMERER presented a little girl who came under his observation last August. There was nothing of interest in

her previous history. The mother stated that the child had eaten some watermelon, and on the following morning, while going down-stairs, she had an attack of cramps. This repeated itself at short intervals, and soon afterwards a bloody discharge was noticed from the anus; in addition, there was rectal tenesmus and vomiting, the picture being a typical one of acute intussusception. These symptoms were allowed to continue without any effort at relief until nine o'clock in the evening of the following day, when the patient was brought to the hospital, where Dr. Kammerer saw her two hours later, that is, about forty hours after the onset of her symptoms. He found the abdomen slightly distended; it was not painful, and over the left side a large, sausage-shaped tumor could be distinctly made out; the apex of the intussusceptum could also be felt per rectum. The child's temperature at this time was 100.5° F. She had ceased to vomit.

Dr. Kammerer said he immediately did a median laparotomy, making a very liberal incision. In this case, as in three previous cases which had come under his observation, he found it necessary to eventrate most of the intestines before reaching the invaginated portion of the gut. It proved to be of the ileocæcal variety, and no difficulty was experienced in reducing the invagination up to the cæcum, but the reduction of the cæcal portion was rather difficult. The abdomen was then completely closed, and the patient made an uneventful recovery.

Dr. Kammerer said the case was rather unusual, as it proved that even after forty hours a good result might sometimes be obtained by operative interference. This should not, however, be taken as a plea for late operative interference.

EMPYEMA; INCISION OF PULMONARY PLEURA.

Dr. Charles N. Dowd presented a boy of nine years, who, in February, 1900, had an attack of pneumonia, which was followed by empyema. When he was admitted to St. Mary's Hospital for Children the pus had broken through the chest wall and caused a bulging between two of the lower ribs anteriorly. Twelve ounces of pus were immediately evacuated at this point, and on the following day a portion of the seventh rib was resected near the posterior axillary line. The case was then dressed with care, and efforts made to expand the lung for about three and

one-half months. At the end of that time there was still a very large sinus leading up to the apex of the lung, and a localized abscess had pointed between the second and third ribs in front.

As the child was not doing well after this long treatment, a secondary operation was done. About three inches of the ninth rib, and smaller portions of the ribs above this as far as the third, together with a corresponding wedge-shaped piece of costal pleura, were removed. This gave a very good exposure of the thickened pulmonary pleura, through which an incision about four inches long was made, and the pleura pushed back from each side. The lung was then seen to expand to a considerable degree, but not as satisfactorily as Delorme describes in speaking of his cases. He states that after his incision the lung expands as an animal's lung does when it is inflated. Drainage was carried from the anterior opening between the second and third ribs to this large lateral opening.

After recovering from the immediate effects of the operation, the boy was sent to the country branch of the hospital at Norwalk, Connecticut, where he could have the advantage of good hygienic surroundings and out-of-door life. The wound healed promptly there, about eight months ago, and has not opened again.

There is a good respiratory murmur over the affected lung, and he uses that side of his chest well in breathing. He has no noticeable lateral curvature of the spine. He shows no sign of tuberculosis, although the long delay in healing suggested such a cause.

Dr. Dowd said this was the third case in which he had incised the pulmonary pleura. One of the cases was complicated with miliary tuberculosis and the lung did not expand. In that case the pleura could not be peeled from the lung tissue and the operation was without benefit. In the second case the pleura was very thin and the lung expanded satisfactorily. The case promised very well at first, and the wound healed, but opened again at a later time, and the patient has since developed tuberculosis in other regions of the body.

In reply to a question, Dr. Dowd said his operation differed somewhat from the Delorme method in the removal of a portion of the chest wall instead of lifting it as a flap and then returning it to its position.

ADENOFIBROMA OF THE BREAST.

DR. DOWD presented a colored girl, fourteen years of age, from whom a tumor of the breast was removed by him about two weeks before. It was the size of a goose-egg, and freely movable between the glandular tissue and the skin, being apparently entirely outside of the breast tissue. It was hard to the feel, and no other growths could be made out either in that breast or the opposite one. It had been noticed for about a year. Upon operation it was found to be distinctly encapsulated, and was shelled out with perfect ease. It proved to be an adenofibroma.

Dr. Dowd said that adenofibromata of the breast are ordinarily found as scattered nodules throughout one breast or both, and they are usually incorporated in the breast tissue. Thirty-seven cases similar to this have been collected from Von Bergmann's clinic by Schimmelbusch (*Archiv für klinische Chirurgie,* Band xliv, Heft 1, p. 102, 1892); and in reviewing them attention was called to the points above mentioned. They are distinguished by their mobility, their hardness, their separation from and non-involvement of the surrounding tissues, and the fact that they are in no sense malignant.

The microscope shows that instead of there being one layer of epithelial cells in the tubules of this tumor, there are several, and in certain parts of the tumor the epithelial elements are found in such profusion that it even suggests carcinoma.

The location of the tumor between the breast and the skin, in its own capsule, suggests the possibility of its development from one of the little portions, or sequestrations, of breast tissue which are often found about the gland.

TYPHOIDAL OSTEOMYELITIS, WITH MULTIPLE LESIONS.

DR. GEORGE E. BREWER presented a young man who entered the City Hospital about eighteen months ago suffering from a number of painful lesions on both legs. His history was that during the Spanish war he had contracted a severe attack of typhoid fever in Cuba, and he spent some time in the hospital there and afterwards in New Orleans. Subsequent to this he developed pains in both legs, which became so severe that he had to give up his work.

At the time of his admission to the City Hospital, eight distinct lesions were made out, two of which were accompanied by slight enlargement of the bone. Four of the lesions were on one leg, involving the tibia and femur, and three on the other. There was also a thickening of the first phalanx of one finger on the right hand. Five of the lesions were freely incised, disclosing circumscribed cavities in the bone varying from one-quarter to half an inch in diameter, and filled with granular matter. There was also some thickening of the periosteum and considerable periostitis. Most of the lesions which were operated on healed very promptly. The lesion on the finger was not opened, and finally broke down. The patient still complains of pain in the femur from time to time, especially when he is exposed to the weather or is run down in health.

DR. FISK said that a year ago he saw a case of typhoidal osteomyelitis in which there were four lesions, one over the crest of the right tibia, another over the ninth and tenth ribs on the right side, a third over the supraspinous process of the right scapula, and the fourth over the left hip. The lesions were incised and cleaned out, and the patient made an excellent recovery.

PLASTIC OPERATION FOR ŒDEMA OF ARM DUE TO CIRCUMFERENTIAL SCAR.

DR. ELLSWORTH ELIOT, JR., presented a man who about two and one-half years ago received extensive burns involving the left upper arm and shoulder. He was treated at the New Haven Hospital, the raw surfaces being covered by skin-grafts. The lesions on the shoulder healed promptly, but the arm did not heal until about six months ago, when he was left with a hard cicatrix, which entirely surrounded the left arm at the junction of the upper and middle thirds. This produced so much constriction that œdema of the elbow and forearm developed, which became so pronounced that he was unable to continue his work as a tinsmith. The cicatrix around the arm formed a deep furrow, the circumference of the arm at this point measuring an inch and one-half less than that of the opposite arm at the same level.

On account of the œdema and the uselessness of the arm, its amputation had been advised; but the patient preferred to have an attempt made to relieve the condition by a plastic opera-

tion. Accordingly, on December 14 last, under ether, this cicatricial band was cut away; it extended down to the deep fascia, and by its removal the biceps muscle was exposed. A long flap, consisting of all structures superficial to the muscular plane and extending as far back as the angle of the scapula, was then dissected from the side of the body, and, still attached by its pedicle to a point just external to the nipple, it was brought around so as to cover the denuded area on the upper arm. When first placed in position, it was cool to the touch, excepting at the point where it was still attached to the body; after the application of warmth, however, for twenty-four hours, it regained its normal temperature, and healing by primary union took place. The attachment of the flap to the chest wall was not severed until a month afterwards, during which time the parts were carefully immobilized, and then only partially; ten days later it was completely severed and the inner edge of the flap was sutured in position. The day after the primary operation the œdema of the arm had entirely disappeared, and, since the division of the pedicle of the flap, the patient has gradually regained the use of his arm. He now states that it is as strong as it ever was, and he is again able to work at his trade.

The wound left on the chest wall by the removal of the flap was closed by skin-grafts and healed without any difficulty. The circumference of the arm over the site of the old cicatrix has increased an inch and a quarter since the operation.

CHRONIC LYMPHANGEITIS.

Dr. Otto G. T. Kiliani presented a physician, who, after a chronic infection from chapped hands, while surgical assistant in the hospital, developed enlarged glands in the axilla, which were extirpated. No tubercle bacilli were found in them. Subsequent to this operation, strings of thickened lymphatic ducts were noticed running from the axilla down the arm and side of the chest. They can be plainly felt and seen, and upon the arm they have the appearance of sinews. The condition is gradually improving.

Dr. Joseph A. Blake said the condition presented by Dr. Kiliani's patient was perhaps due to an obstruction of the lymph vessels, secondary to the removal of the lymph glands in the axilla. This enlargement of the vessels may occur not only on the arm, but on the side of the chest as well.

Dr. Blake said that about a year and one-half ago he re-

moved a tumor of the breast, and the patient has since developed an elephantiasis of the arm due to obstruction of the lymph vessels. The operation was not for carcinoma, but for a fibro-adenoma in a rather elderly woman. The condition in the arm is a pure elephantiasis; it resembles a muscular enlargement, and there is no true œdema whatever.

In reply to a question as to whether the theory of an obstruction of the lymph vessels would explain the thickening of their walls, such as was noticeable in Dr. Kiliani's case, Dr. Blake replied that it would not, unless they had become hyperplastic.

DR. L. W. HOTCHKISS said he had a similar case some years ago after removal of the inguinal glands. The operation was followed, after patient's discharge from hospital, by marked œdema of the corresponding leg and side of the vulva. The speaker said he attributed the condition to obstruction of the lymph channels by reason of the removal of these glands in the groin. The case was lost sight of. The speaker said he had never seen a similar case before or since.

DR. KILIANI rejoined that if the condition in his case were due to obstruction of the lymph channels, some œdema would certainly be present. As a matter of fact, there had never been any œdema of the arm. The strings of thickened ducts are quite painful. The speaker said he regarded the condition as a secondary inflammation of the lymph ducts.

ABSCESS OF THE LIVER.

DR. ELLSWORTH ELIOT, JR., read a paper on the above subject. In connection with his paper, Dr. Eliot showed several cases of abscess of the liver upon which he had operated.

DR. CHARLES L. GIBSON said that Dr. Eliot, in discussing the diagnosis of liver abscess, had failed to mention the presence of peptones in the urine. It is true that peptones are found in the urine in several other conditions, but most readily in abscess of the liver. The test is a very delicate one, and should be made by an expert chemist.

In some instances it is difficult to decide whether we have to deal with an abscess of the liver or pulmonary tuberculosis, especially if there is a perihepatitis with involvement of the pleura, and cough; in such cases the use of the aspirating needle may prove very serviceable, and clear up many dubious cases.

In speaking of the treatment of liver abscess, Dr. Eliot referred to excision of the ribs. Certain foreign writers have called attention to the fact that such an extreme measure was usually undesirable and unnecessary when the abscess reached the surface, and Dr. Gibson said that in two cases which had come under his observation simple incision of the abscess and the insertion of a large tube proved all that was needful.

Dr. B. F. Curtis called attention to the fact that some cases of malignant disease gave rise to symptoms which were very deceptive, and which might easily be confounded with those of an inflammatory condition. The speaker said he recently saw a man of sixty, very rugged, who had always led an out-door life, and who was taken suddenly ill about Christmas-time with chills, high temperature, and tenderness in the right epigastrium. It was supposed that he was suffering from some gall-bladder trouble. He improved somewhat and was brought to a town near New York, where Dr. Curtis saw him. His temperature had gone down, but it still ranged from 100° to 101° F., and he complained of chilly sensations. The area of liver dulness was markedly increased downward, the lower margin of the liver being considerably below the free border of the ribs. The leucocytosis was about 12,000. There was some fluid in the belly and tenderness over the entire liver region. The diagnosis was supposed to lie between abscess of the liver and subphrenic abscess. An exploratory incision, however, revealed a carcinoma of the liver, of unknown origin. The fluid in the belly was hæmorrhagic.

Dr. Kammerer referred to a case of cancer of the cæcum in which he did an ileocolostomy. Subsequently, the patient became icteric, which passed off again, and was followed by symptoms of an acute condition of the liver. He suffered from chills and a high temperature which could not be accounted for. The liver was greatly enlarged, its lower margin being fully three inches below the border of the ribs. The organ was punctured over and over again, without discovering any pus. The high temperature continued for perhaps two months, when the man died. The autopsy revealed a diffuse carcinoma of the liver.

Dr. George Woolsey said, in reference to the uncertainty of diagnosis, that about two months ago, at Bellevue Hospital, he saw an Italian with a rather vague history, who presented

an enlargement of the liver. He complained of pain in the back and on the right side, not very severe. There was no temperature and but little, if any, jaundice. An exploratory operation revealed that the gall-ducts were normal; but there was an enlarged lymphatic gland in the lesser omentum, which led to the suspicion that there was some trouble, perhaps inflammatory, in the liver itself. Anteriorly the liver felt a little soft on palpation. A full-sized exploring needle was introduced in several places to the depth of the needle, but nothing was found. Nothing further was done, and, when the man left the hospital, his condition was about the same as when he was admitted. Some weeks later, when he saw him in the Presbyterian Hospital, there was marked bulging of the liver, with icterus and a temperature elevation. The patient was subsequently operated on by Dr. Eliot, who found an abscess of the liver in the same region Dr. Woolsey had punctured without discovering pus.

DR. ELIOT, in closing, said that in his cases the urine had not been examined for peptones, as no chemical expert was available at that time. In two of the three cases, the urine contained a small amount of albumen, with hyaline and granular casts, which disappeared shortly after the operation.

Dr. Eliot said his remarks regarding puncturing the liver referred more to the danger of puncturing through the anterior wall. When such a puncture is made and we discover pus, some of it is apt to escape and give rise to trouble. If the symptoms indicate an exploratory operation, we do not gain much by exploring with the needle. By an anterior puncture we may also injure intervening organs, such as the gall-bladder or transverse colon. Some years ago Dr. Bryant reported a case in which such a puncture was followed by fatal hæmorrhage.

Dr. Eliot said the operation which he described differed somewhat from that in vogue in France and Germany. In a recent number of the *Centralblatt* (No. 50, 1900), twelve cases of abscess of the liver are reported by M. Hache (Beyroot), in which the primary operation was done, with two deaths from peritonitis. M. Giordano (Wien) reports seventy-two cases in the past six years where the primary operation was done, with a mortality of 41 per cent. The "primary" operation consists in incision and drainage of the abscess directly after the opening of the peritoneal cavity.